

Table 2 Severity of urethritis in men with Reiter's disease or non-gonococcal urethritis (NGU)

Score	No of men with:	
	Reiter's disease (n = 27)	NGU (n = 25)
1	3	0
2	3	2
3	4	5
4	7	9
5	10	9
Total	27	25

group consisted of 27 patients who were in the early stages of an acute first attack of Reiter's disease, and the controls were 25 randomly selected men with NGU. Table 1 shows the point scoring system used to assess the severity of the urethritis, which meant that 5 was the maximum score and 1 the minimum.

Table 2 shows the numbers of men with Reiter's disease or NGU in relation to the severity of their urethritis. The χ^2 test showed no difference between the two diagnoses. As the urethral response showed the same range of severity in Reiter's disease and NGU, neither low grade nor severe urethritis was particularly associated with Reiter's disease. *Chlamydia trachomatis* has been isolated from about half the patients with NGU,² and this organism has also been linked aetiological to Reiter's disease.³ I therefore suggest that the cause and the severity of the urethritis is the same in NGU as in non-dysenteric Reiter's disease, which represents a more widespread clinical response.⁴

Yours faithfully,
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References

- Willkens RF, Arnett FC, Bitter T, et al. Reiter's syndrome: evaluation of proposed criteria. *Ann Rheum Dis* 1979;38(suppl 1):8-11.
- Oriel JD, Reeve P, Wright JT, Owen J. Chlamydial infection of the male urethra. *British Journal of Venereal Diseases* 1976;52:46-51.
- Kousa M, Saikku P, Richmond S, Lassus A. Frequent association of chlamydia infection with Reiter's syndrome. *Sex Transm Dis* 1978;5:57-61.
- Fisk PG. Reiter's disease. *Br Med J* 1982;284:3-4.

TO THE EDITOR, Genitourinary Medicine

New enzyme immunoassay (Pharmacia) compared with MicroTrak (Syva) to detect *Chlamydia trachomatis* in genital tract specimens

Sir,
Microbiology laboratories are faced with a growing demand to diagnose chlamydial infection, mainly from departments of genitourinary medicine (GUM). The methods most widely used are currently either isolation in cell culture, which is labour intensive, or direct immunofluorescent detection of elementary bodies in smears, which is fatiguing. There has therefore been a growing need for a sensitive, specific, and easily performed immunoassay.

This study was carried out to assess the diagnostic agreement between a new enzyme immunoassay (Chlamydia EIA; Pharmacia) and the routine immunofluorescence test (MicroTrak; Syva) used in this laboratory for the past four years.

Urogenital specimens were collected from 90 patients (57 men, 33 women), attending a GUM clinic. The incidence of chlamydial infection in specimens received from this clinic during the past two years was 18%. The patients were selected only on the basis of a high probability of chlamydial infection. Two specimens were taken from each patient (the urethras of men and the endocervices of women), and the order of taking the two swabs was randomised. One swab was used to prepare a direct smear for fluorescent antibody staining; the other was collected into storage buffer (Pharmacia) and stored at -20°C until tested by EIA, which detects *Chlamydia trachomatis* within three hours.

The results (table) show that the Pharmacia Chlamydia EIA was a sensitive (81.3%) and specific (98.7%) test that correlated well (95.6%) with the Syva MicroTrak stain. The order of swab collection made no appreciable difference to the results.

Table New enzyme immunoassay (EIA; Pharmacia) compared with MicroTrak immunofluorescence (Syva) to diagnose chlamydial infection in 90 patients

EIA	Immunofluorescence	
	Positive	Negative
Positive	10	1
Negative	3	76

Sensitivity of EIA 81.3%, positive predictive value 91.3%, specificity 98.7%, negative predictive value 96.9%, agreement with MicroTrak 95.6%, prevalence of *C trachomatis* in study group 14.4%.

Our previous experience with two commercially available EIAs to detect chlamydial antigen showed them to be insufficiently sensitive or specific for routine use. In common with other workers,¹ however, we have found the Syva MicroTrak direct smear test to be rapid, sensitive, and specific compared with culture.

The Pharmacia Chlamydia EIA is rapid, easy to use independent of the skills of a microscopist, not open to criticisms of subjective interpretation, and may be used to test large numbers of specimens. These preliminary results indicate that it is a good alternative to the direct smear test.

Yours faithfully,
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Reference

- Thomas BJ, Evans RT, Hawkins DA, Taylor-Robinson D. Sensitivity of detecting *Chlamydia trachomatis* elementary bodies in smears by use of a fluorescein-labelled monoclonal antibody: comparison with conventional isolation. *J Clin Pathol* 1984;37:812-6.

TO THE EDITOR, Genitourinary Medicine

Chlamydial infection: which antibiotic for patients with acute intermittent porphyria?

Sir,
A woman recently attended our clinic with *Chlamydia trachomatis* infection of the endocervix. She also suffered from acute intermittent porphyria, which raised the question about the most suitable antibiotic to prescribe. Advice was sought from Dr MR Moore DSc, Porphyria Service, Western Infirmary, Glasgow, G11 6NT. Of the range of antibiotics suitable for chlamydial infection (rifampicin, sulphonamides, tetracyclines, erythromycin, and trimethoprim),¹ rifampicin, erythromycin, and sulphonamides are all totally contraindicated, and the action of trimethoprim and tetracycline is uncertain, in patients with acute intermittent porphyria. The least suspicion is attached to tetracyclines, and doxycycline in a single dose of 200 mg followed by 100 mg a day for six days was therefore prescribed; urinary porphyrin concentrations were also measured before and after treatment. In this case it transpired that doxycycline was entirely safe.